b. Documentation

In order to qualify for reimbursement for recovery room services and observation services, the following information must be documented in the recipient's medical record:

i. the time the service begins and ends; and

ii. the reasons the service was necessary for that time period.

c. Physician Payment

In addition to the above observation fee, when a hospital-based physician provides services in connection with observation services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

No physician payment applies to recovery room services.

8. **Significant Procedure APGs**

The methodology for the reimbursement of Significant Procedure APGs will be in effect for outpatient procedures performed on or after October 1, 1997.

a. Scope

As defined by the Division, Significant Procedure Groups consist of groups of most, but not all outpatient procedures, categorized based on CPT and HCPCS Level II, that are covered by the Division, as well as local procedure codes established by the Division. The codes that comprise each Significant Procedure Group are consistent with the latest available update of 3M Health Information Systems' Ambulatory Patient Groups, Version 2.0.

The Significant Procedures that will be subject to bundled, prospective reimbursement are those that fall within APGs 001-237, with some exceptions. These exceptions shall be reimbursed as follows.

APG 057 Respiratory Therapy - see section IV.A.5;
APG 084 Cardiac Rehabilitation - see section IV.A.5;
APG 091 Chemotherapy by Extended Infusion) - see section IV.A.3 or 5, as applicable;
APG 092 Chemotherapy except by Extended Infusion - see section IV.A.3 or 5, as applicable;
APG 139 Hemodialysis - see section IV.A.13;
APG 140 Peritoneal Dialysis - see section IV.A.13;
APG 193 Electroconvulsive Therapy - see section IV.A.5;

b. APG Rate Development

The methodology for developing rates for Significant Procedure Groups is as follows. All paid Medicaid in-state acute outpatient hospital and Hospital-Licensed Health Center claims for RY95 were bundled into Significant Procedure APGs. All other outpatient and E.D. services (e.g., Clinic and E.D. Visits, Lab, Radiology, Ancillaries, Observation and Recovery Room) that were provided one day before, the day of, and the day after a Significant Procedure (but not including physician services), were included in the bundle. The APG charge was then calculated based on the average charges for all surgical claims and other outpatient and E.D. services. A weight was assigned to each Significant Procedure Group based on the relative value of the charges among all instances of each Significant Procedure Group where only one non-consolidated (see section IV.A.8.d) Significant Procedure occurred within the three day window (see section IV.A.8.c). A conversion factor of $386.04, which was based on the average RY95 Medicaid payment per visit for all Significant Procedure Groups that will be subject to APG reimbursement, was calculated based on the following adjustments. The average RY95 Medicaid payment per visit was multiplied by an outlier adjustment factor of 95%, a coding refinement adjustment factor of 97%, and a 95% efficiency discount. The conversion factor was inflated by 3.16% and then 2.38% to reflect price changes from RY95 to RY97. The conversion factor was then inflated by the RY98 update factor of 2.14% to reflect price changes from RY97 to RY98.

The conversion factor was then multiplied by the relative weight of each significant procedure group to determine the RY98 reimbursement rate for each group.

c. Three Day Window

A three (3) day period of time is utilized to bundle all services around a procedure into a Significant Procedure Group. Outpatient and E.D. services (other than physician services) provided by a hospital and its associated Hospital-Licensed Health Centers the day before, the day of, and the day after a Significant Procedure are bundled into the APG. This period is referred to as the "three day window."

d. Multiple Procedures

Multiple Significant Procedures performed within the three day window will be reimbursed at 100% of the APG rate for the procedure in the highest rated Significant Procedure Group, and 50% of the APG rate for each additional Significant Procedure. Multiple procedures where a simple procedure typically accompanies the more complex procedure will be consolidated into one procedure according to the 3M APG consolidation list and will not receive separate reimbursement.

e. Outliers

In those cases where 45% of the hospital's total charges exceed the reimbursement rate for a bundled APG service by $1,872 or more because of the level of intensity and resources required for a particular recipient, the hospital may apply to have these services considered for outlier treatment and priced manually by the Division.

f. Physician Payment

In addition to the Significant Procedure Group payment, when a hospital-based physician provides services, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

9. The Norplant System

Hospitals will be reimbursed according to both the Physician Regulations in 130 CMR 433.000 and the fees established in the most recent promulgation of the DHCFP's Family Planning Regulations (114.3 CMR 12.00), when a hospital-based physician inserts, removes, or removes and reinserts the Norplant System of Contraception. The hospital may only bill for the hospital-based physician payment as the fee (according to the DHCFP's Family Planning Regulations at 144.3 CMR 12.00) represents payment in full for all services associated with the Norplant System of Contraception.

10. Off-Site Radiation and Oncology Treatment Centers

Hospitals that provide radiation and oncology treatment services thorough an Off-Site Radiation and Oncology Treatment Center it subcontracts with or owns will be reimbursed according to the lower of the Medicare fee schedule or the hospital's usual and customary charge. Only those services listed by the Division are reimbursable at the Off-Site Radiation and Oncology Treatment Center. These rates represent payment in full for services and the hospital is not entitled to any additional reimbursement (e.g., clinic visit payments, APGs, physician payments).

To be reimbursed for any services provided at an Off-Site Radiation and Oncology Treatment Center, the hospital must enroll that site with the Division as the appropriate provider type. If the site is not recognized by the Division as an Off-Site Radiation and Oncology Treatment Center provider type, no service provided to a recipient at that site is reimbursable.

11. Audiology Dispensing

Hospitals will be reimbursed for the dispensing of hearing aids by a hospital-based audiologist according to the audiologist regulations at 130 CMR 426.00 et seq., and at the lower of the most current of the DHCFP fees as established in 114.3 CMR 23.00, or the hospital's usual and customary charge.

12. Ambulance Services

Ambulance services shall be classified as either air or ground ambulance services. Ground ambulance services shall be reimbursed by the Division subject to all regulations pursuant to 130 CMR 407.000 et seq. Payment shall be the lower of the rates established by the DHCFP, under 114.3 CMR 27.00, et seq., or the hospital's usual and customary charge.

If the costs of ground ambulance services were included by the hospital in the FY90 cost base for FY90 outpatient department services, no additional reimbursement for ground service ambulance may be billed.

In order to receive reimbursement for air ambulance services, providers must have separate contracts with the Division for such services.

13. Dialysis Services

The Division will reimburse services for End-Stage Renal Disease (ESRD) provided by acute hospital outpatient departments at the lower of the established Medicare "composite rate" of payment as stated in regulation or the hospital's usual and customary charges. Medicaid will recognize all exceptions to the composite rate that are approved by the Health Care Finance Administration.

14. Psychiatric Day Treatment Program Services

For services to recipients who are not assigned or eligible for the MH/SAP, the Division will reimburse acute hospital outpatient department psychiatric day treatment programs which are enrolled with the Division as such according to the regulations as set forth in the Psychiatric Day Treatment Program regulations at 130 CMR 417.401 - 440, at the lower of rates promulgated by the DHCFP, as established in 114.3 CMR 7.03, or the hospital's usual and customary charge. Hospitals may not bill for psychiatric day treatment services in addition to outpatient clinic mental health services if both were delivered on the same day.

15. Dental Services

All covered dental services will be reimbursed by the Division, subject to all regulations at 130 CMR 420.000 et seq., at the lower of the most current rates promulgated by the DHCFP, as established in 114.3 CMR 14.00 et seq., or the hospital's usual and customary charge, except when the conditions in 130 CMR 420.429(A) or (D) apply. When these conditions apply, the Division will reimburse the hospital according to Section IV.A.8.

16. Adult Day Health Services

The Division will reimburse acute hospital outpatient departments as set forth in the Adult Day Health regulations at 130 CMR 404.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 10.00 et seq., or the hospital's usual and customary charge.

17. Early Intervention Services

The Division will reimburse acute hospital outpatient departments as set forth in the Early Intervention Program regulations at 130 CMR 440.401-422, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 49.00 et seq., or the hospital's usual and customary charge.

18. Home Health

The Division will reimburse acute hospital outpatient departments as set forth in the Home Health Agency regulations at 130 CMR 403.401-441, at the lower of the most current promulgation of DHCFP fees as established in 114.3 CMR 3.00 or the hospital's usual and customary charge.

19. Adult Foster Care Services

The Division will reimburse acute hospital outpatient departments for Adult Foster Care services at the lower of the rates certified by the Office of Purchased Services in the Executive Office for Administration and Finance and as set forth in the **Adult Foster Care Guidelines** dated 10/90, or the hospital's usual and customary charge.

B. Emergency Department Services

Rates for emergency department services covered under a contract between the acute hospital and the MH/SAP MCO that are provided to MassHealth patients eligible for or assigned to the Division's MH/SAP MCO shall be governed by terms agreed upon between the acute hospital and the MH/SAP MCO.

1. Emergency Room Services and Level I Trauma Center Services

The applicability of Emergency Department payments described in sections IV.B.1.a-c and IV.B.2.a-c are as follows:

i. Such services provided before September 30, 1997 shall be reimbursed as set forth in sections IV.B.1.a-c and IV.B.2.a-c.

ii. All such services which are not provided the day before, the day of, or the day after a significant procedure as described in section IV.A.8, shall be reimbursed as set forth in sections IV.B.1.a-c and IV.B.2.a-c.

iii. All such services provided the day before, the day of, or the day after a significant procedure performed on or after October 1, 1997 shall be bundled into the reimbursement provided for a Significant Procedure APG in accordance with section IV.A.8, and not in accordance with sections IV.D.1.a-c and IV.D.2.a-c.

iv. Physician services will not be bundled as part of APG Significant Procedure Groups.

v. All conditions and limitations on E.D. services apply regardless of the method of reimbursement.

Hospitals are reimbursed for services provided in emergency departments as described below.

a. Emergency Room Visit and Level I Trauma Center Visit Payment

Rates by wage area were established using the same methodology as described for the clinic visit payment (see Section IV.A.2.a) except for the following:

i. For emergency services, the cost of Level I Trauma Centers were excluded from the calculation of the emergency room visit cost. Separate Level I Trauma Center rates were computed for hospitals with qualifying Level I Trauma Centers.

ii. For Level I Trauma Center services in which the services of the Level I Trauma Center Team is not required, the costs of emergency services provided in the centers were separated from the costs of emergency services provided in other hospitals.

b. Hospitals will not be reimbursed the emergency room or Level I Trauma Center visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following an emergency room or Level I Trauma Center service.

c. Hospitals will not be reimbursed at the emergency room or Level I Trauma Center visit rate for (i) primary care services provided to any recipients (ii) urgent care services provided to recipients enrolled in the PCCP, in an emergency room or Level I Trauma Center between 8:00 A.M. and 9:59 P.M. unless authorized by the recipient's PCC or unless the recipient's PCC is not available for authorization; and (iii) urgent care services provided in an E.D. to recipients not enrolled in the PCCP, when the hospital determines that the recipient has the opportunity to receive urgent care elsewhere (e.g. the recipient's regular physician, an accessible community health center, or the hospital's outpatient clinic).

d. All recipients seen in the E.D. must be screened in the E.D. in accordance with 42 U.S.C. 1396dd et seq. Reimbursement for a screening, will be according to the methodology in section IV.B.3.

e. Physician Payment

In addition to the emergency room and Level I Trauma Center visit payment, when a hospital-based physician provides services during an emergency room or Level I Trauma Center service, the hospital may be reimbursed for such physician services in accordance with section IV.A.1.

For physician services provided by a hospital-based physician for an emergency or Level I Trauma Center service included on the site-of-service list, the hospital will be reimbursed 79% of the fee established in DHCFP Regulations at 114.CMR 16.00,17.00 and 18.00, or 100% of the hospital's usual and customary charge for physician fees, whichever is lower.

2. **Level I Trauma Center Team Services**

Hospitals will be reimbursed for Level I Trauma Center Team services as described below for Level I Trauma Center visits in which the services of a Level I Trauma Team (as defined in Section II) are required.

a. Level I Trauma Team Visit Services Payment

Rates by wage areas were established using the same methodology as described for the clinic visit payment (as described in Section IV.A.2), except that the lower of cost or charge limitation was not imposed.

b. In order to receive the Level I Trauma Team services visit payment, the hospital must document in the recipient's medical record, the necessity for and the provision of Level I Trauma Team services for that visit.

c. Hospitals will not be reimbursed the Level I Trauma Team visit payment when an inpatient admission to the same hospital, on the same date of service, occurs following the Level I Trauma Team service.

d. Physician Payment

In addition to the per visit payment, when a hospital-based physician provides services during a Level I Trauma Team service, the hospital may be reimbursed for such physician services in accordance with Section IV.A.1.

3. **Emergency Department Screening Fee**

Emergency Department Screening fee payments are excluded from the APG methodology.

a. Conditions of Reimbursement

Hospitals will be reimbursed a screening fee only when a hospital-based physician provides screening services to Medicaid recipients in a hospital emergency department as follows:

i. the emergency department physician determines at any hour that a recipient requires elective or primary care;

ii the emergency department physician determines between the hours of 8:00 a.m. and 9:59 PM that a recipient enrolled in the Division's PCCP requires urgent care and the PCC declines to authorize emergency room services; or

iii the emergency room or Level I Trauma Center physician determines that a recipient not enrolled in the Division's PCCP requires urgent care, and the hospital determines that the recipient has the opportunity to receive this care elsewhere.

b. Rate Methodology

The emergency department screening fee is based on the average cost per screening visit and the rate for a comprehensive physician's office visit. The bundled rate includes components for professional services, ancillary services required to determine the acuity of the patient's condition, educational instruction on the use of the Division's PCC/managed care system for recipients enrolled in the PCCP, educational instruction on accessing primary care/urgent services in community health centers, hospital outpatient clinics, and physicians for recipients not enrolled in the PCCP, related educational materials and administrative duties. The E.D. screening fee is the exclusive reimbursement for services provided under the circumstances set forth in section IV.B.1.c. No additional reimbursement, including but not limited to, ancillary services, professional services, and Emergency Department visit payments applies.

D. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.

E. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

F. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates.

G. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rate of such reimbursement. The Division's determination shall be based on the totality of the circumstances.

C. Reimbursement for Unique Circumstances

1. Pediatric Specialty Clinics

Payment for services provided in pediatric specialty (non-primary care) outpatient clinics at pediatric specialty hospitals and at hospitals with pediatric specialty (inpatient) units, per Section II, shall equal the weighted average FY90 Medicaid costs per visit for such clinics, multiplied by an inflation factor of 3.35% to reflect inflation between RY92 and RY93; by an inflation factor of 3.01% to reflect inflation between RY93 and RY94; by an inflation factor of 2.80% to reflect inflation between RY94 and RY95; by an inflation factor of 3.16% to reflect inflation between RY95 and RY96; by an inflation factor of 2.38% to reflect inflation between RY96 and RY97; and by an inflation factor of 2.14% to reflect inflation between RY97 and RY98. Based on total FY90 charges, total FY90 costs, total FY90 Medicaid charges, and total FY90 Medicaid visits totaled across all Division-approved pediatric specialty clinics in each qualifying hospital, the Division shall then calculate a cost-to-charge ratio and the Medicaid weighted average charge per visit, and multiply the latter by the former to calculate the weighted average FY90 pediatric specialty clinic cost per visit.

Qualifying hospitals shall have reported FY90 total Medicaid charges and total Medicaid visits individually for each pediatric specialty clinic approved as such by the Division. (FY91 quarterly data may be substituted if the clinic was not open for a full year in FY90.) Henceforth, hospitals will report corresponding charge and visit data on a quarterly basis.

2. State-Owned Teaching Hospital

a. Subject to section IV.C.2.b, the payment amount for state-owned acute teaching hospitals' outpatient and emergency department services shall be as follows:

The hospital's FY95 total outpatient charges are multiplied by the hospital's overall outpatient cost to charge ratio (the hospital's outpatient cost to charge ratio is calculated using RSC403 FY95 total outpatient costs located on Schedule II, column 10, line 114 as the numerator and total outpatient charges located on Schedule II, column 11, line 114 as the denominator) in order to compute the total outpatient costs. The total outpatient costs are then multiplied by the inflation rate of 3.16% to reflect inflation between RY95 and RY96, and 3.28% to reflect inflation between RY96 and RY97.

b. Any payment amount in excess of amounts which would otherwise be due any state-owned acute teaching hospital pursuant to sections IV.A.1-19 and IV.B.1-3, is subject to specific legislative appropriation.

D. Upper Limit Review and Federal Approval

Payment adjustments may be made for reasons relating to the Upper Limit, if the number of hospitals that apply and qualify changes, if updated information necessitates a change, or as otherwise required by the Health Care Financing Administration (HCFA). If any portion of the reimbursement methodology is not approved by HCFA, the Division may recover any payment made to a hospital in excess of the approved methodology.

E. Future Rate Years

Adjustments may be made each rate year to update rates and shall be made in accordance with the hospital contract in effect on that date.

F. New Hospitals

The rates of reimbursement for a newly participating hospital shall be determined in accordance with the provisions of the RFA to the extent the Division deems possible. If data sources specified by the RFA are not available, or if other factors do not permit precise conformity with the provisions of the RFA, the Division shall select such substitute data sources or other methodology(ies) that the Division deems appropriate in determining hospitals' rates.

G. Hospital Change of Ownership

For any hospital which is party to a merger, sale of assets, or other transaction involving the identity, licensure, ownership or operation of the hospital, the Division, in its sole discretion, shall determine, on a case by case basis (1) whether the hospital qualifies for reimbursement under the RFA, and, if so, (2) the appropriate rate of such reimbursement. The Division's determination shall be based on the totality of the circumstances.